Medicaid Work Requirements Debate
Policy Analysis

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Executive Summary

Whether welfare programs and social insurance programs should incorporate behavioral stipulations has long been debated throughout history. This debate resurfaces again with the introduction of the opportunity for states to apply to Center for Medicare and Medicaid Services (CMS) to incorporate work requirements as a stipulation of eligibility to remain on Medicaid, the joint state-federal health insurance program for low income individuals that is also the largest source of health insurance in the nation. This is the first time in history that CMS has approved work requirements. Previously they have denied requests stating that it did not align with the goals of the Medicaid program (Department of Health and Human Services, 2016).

The policy change of Medicaid Work Requirements is an extremely important one due to the extent of potential impact these changes could have, coupled with the scope and reach of the Medicaid program. According to surveys completed by the Kaiser Family Foundation in 2016, there were approximately 24.6 million non-SSI, non-elderly adults receiving Medicaid, with various work statuses and reasons for not working ranging from full and part time employment, caregiving responsibilities, illness, or currently furthering education (KFF, 2018) . This policy has the potential to drastically change how Medicaid recipients receive health care across the country, affecting millions of adults currently relying on Medicaid for their access to health care.

On March 12th, Minnesota took the first step to joining 8 other states in applying for work requirement waivers through a bill that would require the State Commissioner of Human Services to implement work requirements in Minnesota's Medicaid program known as Medical Assistance. In Minnesota alone, this is estimated to affect approximately 398,000 Minnesotans who would be subject to work requirements in a given month (Minnesota Department of

Management and Budget, 2018) and put them at risk of losing their coverage if not able to comply (This is Medicaid, 2018).

This paper begins by exploring the history behind the debate of work requirements in welfare programs as well as the political context that precipitates the approval of applying work requirements to Medicaid for the first time in history. An in-depth analysis of the potential problems this policy change claims to address is provided. The problem analysis is followed by a policy analysis of the controversial issue surrounding Medicaid work requirements, specifically focusing on the current debate at a local level within the state of Minnesota. Proponents of the work requirements argue that work requirements will improve health of the poor, increase employment, and decrease costs. However, an in-depth analysis of the way the problem is framed in the current political context, and how these policy changes could impact access, health, employment and costs illustrates that Medicaid work requirements are likely to result in unintended consequences and be counterproductive to original goals, resulting in decreased access to care, poorer health outcomes, less employment, and increased costs. Additionally, it threatens the accomplishments of decreasing uninsured rates that have been achieved by the Medicaid expansion as part of the Affordable Care Act. This analysis supports the stance that implementing Medicaid work requirements in Minnesota and other states is detrimental to the health and wellbeing of Medicaid recipients, creates a barrier to necessary health and mental health care, will not significantly impact rates of employment, and may disproportionately affect marginalized populations. It is recommended that advocates and lawmakers strongly oppose Medicaid Work Requirements in Minnesota and instead pursue policies that continue decrease barriers to health care and employment while increasing access to resources and necessary infrastructure to support gainful employment opportunities.

Introduction and Background

What is Medicaid?

Medicaid is a health insurance program jointly funded between U.S. federal and state government, that was designed to provide health insurance to low income individuals (Medicaid.gov, 2018). Medicaid was established in 1965 through the Title XIX of the Social Security Act at the same time that Medicare was created and signed into law by President Lyndon Johnson. The eligibility was originally tied to cash assistance programs such as SSI or AFDC, however changes in policy over time transformed it to an income based health insurance program and slowly expanded eligibility to other groups (KFF, 2018). All states have a Medicaid program and must operate within guidelines that are set by the federal government through the regulatory body known as Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services (CMS 2018). States are allowed flexibility in how the program is administered, what is covered, how providers are reimbursed, etc., therefore, programs may differ widely in operation and coverage from state to state (KFF, 2018). According to a 2017 enrollment report, Medicaid provided coverage to 68 million people in the United States, including low income adults, children, pregnant women, the elderly, and individuals with disabilities. Medicaid is the largest source of health insurance in the country at this time (CMS, 2017). Eligibility requirements may vary state to state, however overarching guidelines mandate by law that states provide health insurance to certain groups such as low income families, pregnant women and children, and anyone receiving SSI (thus determined disabled by Social Security Administration) (CMS, 2018). Prior to the Affordable Care Act, Medicaid income guidelines were far below the federal poverty levels or required individuals to

meet "categorical eligibility" such as qualifying for SSI or other cash assistance programs, this left millions of individuals in poverty without coverage for health insurance. (KFF, 2018).

Affordable Care Act and Medicaid

A significant change to Medicaid, referred to as Medicaid Expansion, was implemented as a result of the ACA in 2010. The expansion aimed to close the uninsured gap in the United States by mandating the expansion of Medicaid to include previously left out groups, such as low-income adults without children. This made Medicaid available to non-elderly adults with income up to 138% of the Federal Poverty Level ($16,753 for individuals as of 2018). Prior to the ACA, individuals without dependent children, no matter how low their income, were not eligible for Medicaid. The ACA changed this by mandating that states expand eligibility to low income adults without dependents.

In the 2012 case *National Federation of Independent Businesses vs. Sebelius*, the Supreme Court ruled that the mandate for Medicaid expansion was unconstitutional and was excessive enforcement on behalf of CMS, thus the expansion was changed to an optional component of the program that is left up to states to determine if they would implement or not. (KFF, 2012). As of January 2018, 33 states have decided to expand Medicaid (see appendix A) (KFF, 2018). In 2013, The Congressional Budget Office estimated that as a result of optional versus mandated Medicaid expansion, an estimated 4 million less people will be covered by the year 2023. (Congressional Budget Office, 2013). Regardless, the ACA has expanded eligibility to many more children and adults (in states that opted into expansion) resulting in a significant increase of about 12 million additional people who were newly insured as of 2016 (KFF, 2018).

Medicaid currently covers some of the U.S.'s most vulnerable populations. For example, 76% of low income children are covered by Medicaid. Additionally, 45% of nonelderly adults

with disabilities receive coverage through Medicaid, and approximately 62% of residents in nursing homes receive coverage through Medicaid. There is also flexibility for States to use Medicaid to help families of higher incomes cover costs of medical procedures for children with disabilities. Medicaid also assists about 20% of individuals on Medicare by supplementing coverage for gaps in services covered such as long-term care (KFF, 2018) (See Appendix B).

Medicaid covers a range of services, including preventative care, standard medical care, mental and substance use care, and, in some states, additional specialty services such as prescriptions, physical therapy, eyeglasses, and dental care. Medicaid also has developed coverage for home and community based care and other long-term care services, which distinguishes it from a lot of commercial insurance plans. (KFF, 2018). By providing insurance coverage for some of the most vulnerable, many argue that Medicaid decreases the amount of emergency room visits and unpaid hospital bills, resulting in lower premiums for all (ObamaCare Facts, 2016). Medicaid expansion allows for more risk protection for a vulnerable group by making preventative care more accessible and decreasing more costly visits.

History of Work Requirement Debate

Whether or not "able bodied" recipients of welfare, social aid or social insurance programs should be required to adhere to certain behavioral requirements, or other stipulations such as work requirements, has been a controversial issue amongst advocates, politicians, and policy makers throughout history. In 1988 The Family Support Act required states to run "welfare to work" programs and, in 1996, the Personal Responsibility and Work Reconciliation Act, which is also known as "Welfare Reform", was passed with proponents claiming a reduced reliance on public assistance and increased employment amongst welfare recipients (Blank, 1997). This Welfare Reform of 1996 terminated the cash assistance program known as Aid to

Families with Dependent Children (AFDC) and, in its place, created Temporary Assistance for Needy Families (TANF) and limited cash assistance while enforcing increasingly strict work requirements. For example, TANF, under the Welfare Reform, required a two-year maximum of eligibility, and, in order to continue to seek assistance, recipients had to be working or in a work program. Welfare Reform gave states more flexibility over how they designed and implemented the TANF program and changed the administration of funding from joint federal and state funding to a block grant (Blank, 1997). This showed a shift towards giving states more control and discretion over determining who is deserving of assistance and also placed more emphasis on a shift towards stipulations attached to benefits, such as work requirements.

The work requirement debate can also be illustrated through SNAP reforms. The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is one of the nation's largest safety net programs serving 45 million participants (SNAP to Health, 2016). The program is administered by the U.S. Department of Agriculture and provides participants who have limited assets, and who are at or below 130% of the Federal Poverty Level, with an electronic benefit card (EBT) which can be used to purchase food at certified grocery providers (SNAP to Health, 2016). Legislators and advocates from the right have proposed reforms that the program include requirements that recipients be working, or looking for work, in order to maintain eligibility for the program, suggesting that the current program creates a disincentive for individuals to look for employment (Heritage Foundation, 2012).

Attempts by several states have been made to impose work requirements on Medicaid. In the past. However, prior to 2018, these proposals have always been denied. For example, states such as New Hampshire, Ohio, and Arizona have previously submitted proposals for work requirements and were denied under the Obama Administration (Dickson, 2016). On November

1, 2016, a letter addressed to Jeffrey Myers, Commissioner of New Hampshire Department of Health and Human Services, from Vikki Wachino, Director with CMS, denied New Hampshire's request to implement work requirements explaining "CMS is unable to approve the following requests," (including a proposal for work requirements among other eligibility stipulations) further stating that the proposed work requirement could "undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program." (Department of Health and Human Services, 2016). Similar responses from CMS have been issued to Ohio, Arizona, and Kentucky when they proposed similar eligibility requirements prior to 2018.

Policy Shift: Medicaid Work Requirements in 2018

Despite being previously denied, states continued to put pressure on CMS to approve Medicaid work requirements. The Trump Administration suggested that it would be more open to work requirements than the Obama Administration had been (Pear, 2017). This appears to be true, as momentum shifted towards work requirement stipulations once again with the January, 2018 announcement of a new policy that allows states the flexibility to impose "community engagement" stipulations, in the form of work requirements, as a condition of eligibility for recipients of Medicaid (CMS, 2018). States have the option to implement this policy as part of the Medicaid program through approved waivers.

CMS describes the goals of this policy is as "promote better mental, physical, and emotional health in furtherance of Medicaid program objectives" and to "help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program objectives." The policy was introduced on January 11, 2018 via letter from the director of CMS, Brian Neele, addressed to state directors of Medicaid. The letter states that "CMS will support

state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries including "non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability." They describe activities offered to help meet the requirements could include "career planning, job training, referral, and job support services." (CMS, 2018) Additionally, CMS indicated that they support states' "efforts to align SNAP or TANF work or work-related requirements with the Medicaid program as part of a demonstration authorized under section 1115." (CMS, 2018).

The announcement explains that states can apply to participate in demonstration projects under section 1115 of the Social Security Act (CMS, 2018). Section 1115 of The Social Security Administration Act permits states to apply for "experimental, pilot, or demonstration project which in the judgment of the Secretary, is likely to assist in promoting the objectives" of specific titles under the Social Security Act, including title XIX which includes Medicaid. Section 1115 explains that through these demonstration projects "the Secretary may waive compliance with any of the requirements" of certain sections for periods of time that allow states to carry out such demonstration project (Social Security Administration, 2014).

The CMS letter outlines that by participating in the demonstration states are required to offer supports and have strategies in place to help beneficiaries meet the requirements, and "link individuals to additional resources for job training or other employment services, child care assistance, transportation, or other work supports to help beneficiaries prepare for work or increase their earnings." (CMS, 2018). However, CMS then goes on to explain that states will have to find their own ways to provide the funding to be able to meet this requirement, as evidenced by statement in the letter describing that "this demonstration opportunity will not

provide states with the authority to use Medicaid funding to finance these services for individuals." (CMS, 2018).

In addition to requiring states to provide resources and supports to help beneficiaries meet these new requirements, states are also required to develop plans for monitoring and evaluation of the demonstration project. States are required to submit quarterly and annual reports with approved metrics. States must collect ongoing data on the work and community engagement initiatives, combined with "metrics aimed at monitoring beneficiary enrollment and termination for failure to meet program requirements, access to services for both beneficiaries and individuals terminated for failure to meet the requirements, and the overall functioning of the demonstration." (CMS, 2018).

As of March 5, 2018, ten states have submitted requests for approval to implement Medicaid work requirements under Section 1115, and three states (Kentucky, Arkansas, and Indiana) have been approved. The remaining states still pending approval include: Wisconsin, Utah, Arizona, Kansas, Mississippi, New Hampshire, and Maine (See Appendix C) (KFF, 2018). The states' proposals vary in terms of exemptions, what they consider "work activities," and the number of hours they require (See Appendix D) (KFF, 2018). For example, some states have set their requirement to be a total of 80 hours of work activity or community engagement per month, whereas other states set the criteria to be 20 or even 30 hours per week (KFF, 2018). Other differences include the age of the exempted. Some states consider anyone 50 and over exempt from the requirement, whereas other states have set the age at 60 or 65 and older (KFF, 2018). Some states have made exemptions for several other populations such as those who are disabled/medically frail, students, caregivers, anyone experiencing a qualifying catastrophic event, those in drug treatment, or those receiving unemployment (for example Arizona).

However other states are much stricter and the only exemptions they have outlined are for elderly and those who are caregiving (for example Kansas). The type of activities that qualify as "work activities" vary as well. For example, some states are including volunteer work, while others do not consider this an eligible activity to count towards required weekly or monthly hours. (KFF, 2018).

On March 12, 2018, Minnesota took the first step to joining the other eight states applying for work requirement waivers through a bill sponsored by Minnesota Speaker Kurt Daudt and Representative Kelly Fenton (R-Woodbury) that would require the State Commissioner of Human Services to seek a waiver from CMS to implement work requirements. A companion bill was also introduced in the Senate (SF 3611). The bill states "By October 1, 2018, the commissioner of human services shall apply to the Centers for Medicare and Medicaid Services for a section 1115waiver to allow the state to implement a medical assistance work and community engagement requirement for able-bodied adults who meet the definition of 'qualified individual,' in order to improve enrollee health and well-being." (MN House of Representatives, HF 3722). Speaker Daudt explained that the rationale for the bill was that the cost of Medicaid in Minnesota's state budget has increased almost 2 billion over the past two years (Pioneer Press, 2018).

Political Context

A look at the shift in political context as well as beliefs and values of key players can help one understand how Medicaid work requirements have picked up momentum when just within the past five years several requests for this same thing have been denied with the rationale that they do not adhere to the objectives and overall goals of the Medicaid program. Many had predicted that the Trump Administration would make drastic changes to the ACA, as well as

many welfare programs and social insurance programs. A letter from the first Secretary of Health and Human Services) under the Trump Administration to state governors in March 2017, also included hints that these changes were on the horizon (Department of Health and Human Services, 2017). This letter was sent out shortly after Seema Verma was appointed the new head of Center for Medicare and Medicaid. Seema Verma has a history of criticizing Medicaid as creating dependence on government amongst the poor and calling for reforms to the waiver, process citing it as a barrier for states to get creative with their Medicaid programs (Quinn, 2017). She also became well known in the health policy world as a result of her consulting and advisory to republican states on how to make their Medicaid programs more conservative and allow for more "personal responsibility" on behalf of Medicaid recipients (Quinn, 2017). At this point, almost all proposals submitted to CMS have come from Red States.

Currently, as well as historically, the idea of work requirements is being championed by the GOP. Several statements from republican legislators provide evidence for this. For example, Arizona state Senator Nancy Barto, who has advocated in the past for provisions to allow for Medicaid work requirements, has stated that there is a "serious problem of welfare benefits becoming an incentive not to work" and that the fiscal consequences of this are "unsustainable" (Arizona Capitol Times, 2016). She was further quoted saying "We want certain controls in order to help the federal government keep its obligation that they've made, contract with the poor, receiving health care...But we want to make sure that we're really serving those that are needy." (Arizona Capitol Times, 2016). Similar sentiments have been echoed by other GOP lawmakers and officials and illustrate a belief that individuals are abusing the system, which is costing states, and that these individuals are disincentivized to work. Illustration of this shift in political context and leadership, beliefs that Medicaid is keeping people poor lacking "personal

responsibility," and costing states due to fears that people are "taking advantage of the system," provides context for how this policy change became a reality despite being a reoccurring debate throughout history.

Problem Analysis

The core problem underlying the need for Medicaid work requirements appears to vary depending on who is framing the problem. According to CMS and proponents of these work requirements, there appears to be three explicit problems they outline including: 1) unemployment amongst Medicaid recipients 2) unemployment may subsequently contribute to poorer health amongst recipients and 3) costs of Medicaid are growing. However, there also appear to be more implicit problems that are more clear when looking at underlying sentiments from supporters of the work requirements. These more implicit problems include overdependence on government, lack of "personal responsibility", disincentives to work, and abuse of welfare programs.

When looking at the letter from CMS introducing the option for states to implement a Medicaid work requirement, it appears that the focus is on the problem that unemployment has been associated with poorer health outcomes. For example, the CMS letter, when giving a rationale for why the demonstration projects are needed, explains that unemployment is generally "harmful to health." The letter cites that studies have shown that unemployment is correlated with higher mortality, poorer general and mental health, increased medical visits, and higher hospital admissions (CMS, 2018). They also report in the letter that studies have shown that employment has a "protective effect on depression and general mental health" and also cite a study that "unemployed Americans are more than twice as likely as those with full-time jobs" to

indicate currently living with or being treated for depression (CMS, 2018). Based on these statements, it appears that CMS is framing the core problem as the negative health effects that unemployment has on Americans.

Although CMS is trying to draw a direct link between unemployment and negative physical and mental health, it is also important to identify underlying sentiments and themes around overdependence on government, abuse of benefits/disincentives, and rising costs (The Heartland Institute, 2017) when discussing topics such as work requirements. These sentiments have predominantly been expressed by representatives of the GOP. These themes are evident by several quotes from supporters of the Medicaid work requirements in various states. For example, current Speaker of the House Paul Ryan was quoted in 2015 stating, "We don't want a dependency culture. Our concern in this country is with the idea that more and more able-bodied people are becoming dependent upon the government than upon themselves and their livelihoods." (On the Issues, 2016). There also appears to be a fear that the "truly needy" or "worthy poor" should be the only people receiving assistance implying that there are individuals using welfare and assistance that do not actually need it. This can be evidenced by Paul Ryan's statement that there is a need for "implementing reforms that give states more flexibility to meet the needs of low-income populations & to make sure that the truly needy receive the assistance" (On the Issues, 2016). Additionally, Medicaid spending has grown over recent years (CMS, 2016), and Republicans continue to express that this is a problem and urge ways to cut costs (Consumer Reports, 2017).

Potential Causes of the Problem

Legislators and conservative health policy advocates argue that the original program creates a disincentive to work that leads to continued higher unemployment rates, continued

poverty, and less than desirable health outcomes for Medicaid recipients. However, other sources argue that the majority of Medicaid recipients actually are already working if able (KFF, 2016). For example, studies in 2016 have shown that out of the approximately 25 million non-SSI Medicaid receiving adults under age 64, (60%) are working, and 79% are in families with at least one worker (nearly 64% with a full-time worker and 14% with a part-time worker) (See Appendix E) (KFF, 2016). Additionally, the causes for unemployment are often due to a variety of reasons such as caregiving responsibilities for other family members and children with disabilities or currently pursuing education. Many individuals on Medicaid face barriers to employment such as minimal education (KFF, 2016).

If many Medicaid are currently employed, however that their full time employment salary is still so low that they still qualify for Medicaid (KFF, 2018), this signifies another potential source of the problem could actually be low wages. 51% of Medicaid recipients who work are employed full time. Studies by the Kaiser Family Foundation point out that an individual working full-time for a full year receiving the federal minimum wage would earn an annual salary of just over $15,000 a year, leaving them at about 125% of poverty level which would still qualify them for Medicaid under expansion (KFF, 2018). Here lies a problem with minimum wages when individuals are working full time and still not able to remain above 138% of the federal poverty level. Additionally, more than one third of Medicaid recipients who are not on SSI still cite disability or illness as a reason for not working (KFF, 2016). This signifies that there are several recipients who have not yet been “officially” deemed disabled by the Social Security Administration, which is a status that has been known to take years for some people to achieve.

The problem may not necessarily be that people are taking advantage of the program or disincentivized to work, but more realistically the majority are working and those who are not are not able due to barriers such as a disability but do not yet have the official label from the Social Security Administration that exempts them from this. The source of the problem may also be better explained by the statistics that show that out of 9.8 million adults on Medicaid who are not working, 30% are taking care of a family member or household, 15% are pursuing higher education, 9% are retired, and 6% have difficulty finding work (KFF, 2018). Another explanation that contributes to the source of the problem is that many recipients work in industries where hours fluctuate (service/restaurants and construction), depending on time of year or for other reasons, making it difficult to get coverage through employers and needing to rely on Medicaid (Center on Budget and Policy Priorities, 2018).

In Minnesota, conservative law makers continue to express concern about increased spending on Medicaid. In Minnesota, total spending on Medicaid services provided to enrollees in 2016 reached approximately $11.4 billion (Minnesota Department of Human Services, 2018). The increases in spending are largely explained due to Medicaid expansion. However, Medicaid expansion also resulted in the state receiving more federal dollars through higher match rates for this population. Additionally, Minnesota's increased use of home and community based services is meant to serve high needs populations in order to keep them in their homes and out of more expensive facilities, which is argued to be more cost effective and person centered in the long run. For example, The Medicaid program in Minnesota spent more on home and community-based services than any other service totaling $3.3 billion (29%) (Minnesota Department of Human Services, 2018). The increase in spending is also related to adjustments in rates for services that were increased over past years in order to allow for organizations and care

providers to provide quality services and run sustainable programs to continue to serve these populations (Minnesota Department of Human Services, 2018). According to the data collected and analyzed by Minnesota Department of Human Services, the overall cost effectiveness of Minnesota's Medicaid program has increased (Minnesota Department of Human Services, 2018).

Policy Analysis

As described above, the problem is currently defined by proponents of Medicaid work requirements in terms of unemployment amongst Medicaid recipients, subsequent negative health outcomes, and rising costs. Proponents claim that Medicaid Work Requirements can address these problems. The following provides an in depth policy analysis of Minnesota's specific Medicaid work requirements proposal through bill HF 3722 (and companion senate bill SF 3611). The analysis examines stakeholders, goals, target populations, and overall administration and financing. Additionally, this analysis outlines where this policy change fails to fit the need of the aforementioned problems and highlights the potential negative consequences of additional barriers to employment, poor impacts on health due to loss of coverage, increased costs, and how this might impact specific populations.

Stakeholders

Several populations are affected by the proposed Minnesota Medicaid work requirements. The policy affects any individuals currently unemployed (for various reasons) and reliant on government assistance program, specifically Medicaid in this case. More specifically, we know Medicaid is made up of subpopulations including individuals who are unable to work for various reasons including caregiving responsibilities, illness, or currently furthering education (KFF, 2018). It also impacts lower income individuals and some of the nation's most vulnerable people by creating additional stipulations in order to meet these requirements to keep

access to health care. It will also affect Medicaid recipients who are already working due to having to now report to regulatory bodies on their hours.

On a Federal level, the regulating body of CMS is a major stakeholder as well as they introduced this option to states and will subsequently oversee the implementation. They also have a stake in terms of costs or savings that might occur because of these policies.

The definition of the problem and proposed policy solution impacts the Minnesota state government by giving them more options to utilize demonstration projects, and if proceed will be responsible for implementation, monitoring, and oversight. It will also impact Minnesota state government in either costs or savings, and will require efforts to develop a plan for monitoring and evaluating the project to adhere to requirements by CMS.

The problem and policy proposal also impacts Minnesota social service agencies and local government bodies such as counties, who are supposed to increase support and connection to resources to help provide solutions to this problem. It can be argued that this problem also impacts taxpayers, as social services, government assistance, and health care costs for uninsured or underinsured are often covered by taxpayer dollars.

Goals

According to the language written in the bill that was proposed to the Minnesota House of Representatives, the more explicit goal of this policy change is to "improve enrollee health and wellbeing", improve employment rates and decrease costs. (MN House of Representatives, HF 3722). However, there appears to be additional less explicit goals around addressing dependence on welfare and preventing abuse of the program. In a press conference, Representative Fenton describes the goal of the bill is to increase participation in the workforce and prevent dependency on welfare, stating "Rather than growing the number of people on

welfare, we should be growing the number of people who are able to move off welfare and into good-paying jobs, and participating in Minnesota's growing economy," (MN House of Representatives, 2018). Representative Kurt Daudt supports this goal by citing that the need for the bill is driven by the fact that since Democratic Governor Mark Dayton has taken office, enrollment in Medicaid has nearly tripled (MN House of Representatives, 2018). Another goal of the bill appears to be to differentiate between who actually is really in need of the program, which relates back to the original ideology outlined in the problem analysis of an underlying sentiment of trying to define who is "truly needy" or the "worthy poor." This is evident in Daudt's statement "if we don't put reforms in place like this, those growing budget numbers are going to simply mean that we can't afford to take care of people that really need these programs." (MN House of Representatives, 2018).

The goals and quotes outlined above by the sponsors and authors of the bill provide insight into the assumptions that these policy makers are making, as well as inherit values they possess. Daudt's statement highlighting the need to reform Medicaid to be able to "afford to take care of people that really need these programs" (MN House of Representatives, 2018) appears to imply that Republican legislators have a belief that there are many people using the program who do not actually need it. They also appear to assume that the number of Medicaid recipients will continue to grow, and that there is an overdependence on these programs and that spending has reached unacceptable limits. For example, on March 12, 2018 Daudt explained fears that public assistance programs, such as Medicaid, were going to "eat the state budget." (MN House of Representatives, 2018). Another assumption being made is that the current program creates a disincentive to work, and that there are high rates of unemployment in general amongst Medicaid recipients and that a significant amount of Medicaid recipients are capable of working. These

assumptions appear to be driven by values of decreasing spending and avoiding "handouts." It appears that these policy makers also value "personal responsibility." These assumptions appear to be consistent with studies on ideological foundations of individuals that identify as Republicans. For example, studies highlight that Republicans are less likely to believe that the uninsured have difficulty gaining access to care, Republicans are significantly less likely than Democrats to support health care reforms that seek to decrease barriers to care concluding that they are also less likely to provide political support for ongoing financing of health care reforms (Oakman et al., 2010).

Target Population

According to HF3722, qualified individuals who will be subject to adhere to the work requirements in order to maintain their Medical Assistance include: "able bodied" Medicaid Recipients which specifically points to qualified individuals including parents and caretakers, adults without children, and children ages 19 and 20 (MN House of Representatives, HF 3722). This is estimated to affect approximately 398,000 Minnesotans who would be subject to work requirements in a given month (Minnesota Department of Management and Budget, 2018) and put them at risk of losing their coverage if not able to comply (This is Medicaid, 2018).

Exempt individuals include recipients who meet the following criteria: pregnant, age 18 or younger, elderly age 60 and older, "working a minimum of 30 hours per week or earning weekly wages at least equal to the federal minimum wage multiplied by 30 hours," students enrolled at least half time, sole caregiver to a child under 18 who is "incapacitated," deemed disabled by state or federal program (such as SSA), "medically frail" (to be judged by commissioner), determined physically/mentally unfit for employment (established by a professional regarding undetermined criteria), already adhering to work requirements of MFIP,

and enrolled in a substance use treatment program (MN House of Representatives, HF 3722). The work requirement will begin after the first three months of eligibility on Medicaid, and would require recipients to meet 80 hours a month of various "community engagement activities" and report to regulating bodies on a monthly basis. The bill includes that in order to satisfy requirements via participating in workfare program, that the "qualified individual must also accept any bona fide offer of suitable employment." (MN House of Representatives, HF 3722). Legislators reported that they modeled the target populations and qualified individuals, as well as specific requirements from proposals submitted by Kentucky and Arkansas.

Fit of Medicaid Work Requirement to Perceived Problem

As the problem is defined currently, supporters of the policy change argue that stakeholders who would benefit from the implementation of work requirements include state governments claiming that the policy will address increased costs, which subsequently impacts taxpayers. Additionally, CMS argues that recipients of Medicaid will benefit as a result of the policy change, due to claims that it will lead to increased employment rates, increased income and pulling them out of poverty, thus resulting in better mental and physical health (CMS, 2018). In this view, CMS also might believe they benefit due to having to provide less support in the long term, subsequently lowering the amount of federal dollars spent towards insuring the poor.

However, opponents of the policy change argue that the policy change could actually harm current Medicaid recipients, and instead of increasing opportunities to work will actually create barriers to obtaining health care resulting in a loss of coverage (KFF, 2018) leaving them with poorer health outcomes, no employment, no access to healthcare, and sinking further into poverty with worsening physical and mental health. With this perspective, taxpayers will also face a loss due to having to contribute more funds to higher costing services such ED visits

because of a larger uninsured population, and state and counties will have increased administrative costs (This is Medicaid, 2018). A closer analysis on how the policy change will affect employment/work, health outcomes, and costs, as well as additional impacts on access to care and who will be impacted the most, highlights the potential unintended consequences, inequity, and inefficiencies of this policy.

- **How will Medicaid work requirements impact health outcomes?**

If the problem is one of improving the health and wellbeing of Medicaid recipients through employment, it appears counterproductive to create an additional barrier to a necessity of quality health and wellbeing which is access to health care. For example, policy experts predict that many individuals (including those who are already working) could lose coverage due to the burdensome and complex process of tracking and reporting hours and filing necessary paperwork, and adhering to ongoing deadlines related to the work requirements, which will cause them to lose coverage or have lapses in coverage (Minnesota Budget Project, 2018). This in turn prevents them from accessing necessary medical and mental health treatment and care, as well as getting necessary medications, which is likely supporting their ability to work in the first place (Minnesota Budget Project, 2018). Additionally, studies support the claim that the uninsured fare far worse in several areas, related to health, compared to those who are insured, and are likely to put off care for as long as possible due to costs, which leads to more severe chronic illness with higher costs in the future that could have been treated or prevented had they had access to preventative visits (KFF, 2016). This is also supported by The Oregon Health Insurance Experiment which found that Medicaid coverage results in an increase use in outpatient preventative care visits such as cholesterol monitoring and mammograms and without

this coverage individuals are significantly less likely to access this type of care (Baiker et al., 2013).

Additionally, data from The Oregon Health Insurance Experiment provide evidence that Medicaid health insurance increases recipients self-report of health quality from “good to excellent health” vs "fair or poor health” by 25 percent (Baiker et al. 2013). The Oregon Health Insurance Experiment also concluded that Medicaid coverage resulted in a significant decrease in rates of depression amongst recipients compared to those who were not enrolled in the Medicaid program (Baiker et al. 2013). This data challenges claims by CMS connecting work requirements to improved mental health and suggests that a loss of Medicaid coverage could result increased rates of depression. CMS and proponents of the Medicaid work requirements argue that unemployment is bad for health, however losing access to health care would be just as bad if not worse for individuals’ overall health.

When TANF program underwent significant reforms that included the incorporation of work requirements and sanctions, research has shown that, over time, the program has actually resulted in an increase in poverty levels associated with an increased risk for risk for long-term negative employment and health outcomes (Center on Budget and Policy Priorities, 2016). Many have argued that the program is not meeting its originally attended goals and actually leaving recipients “far worse off” than prior to the reforms by not effectively providing a safety net (Center on Budget and Policy Priorities, 2016). Medicaid work requirements mirror some of the reforms to TANF that have been proven to result in an increased risk for negative health impacts on recipients.

- **How will Medicaid work requirements impact employment?**

The claim that incorporating work requirements in order to solve a problem of unemployment amongst recipients of Medicaid is misguided. Many critics of the policy argue that this claim refers to a "nonexistent problem." The following evidence shows that Medicaid does not create a disincentive to work (Baiker et al, 2013), most recipients are already working (KFF, 2016), and that lessons from TANF show us that the Medicaid work requirement could actually create an additional barrier to employment for work recipients.

Proponents of Medicaid work requirements continue to refer to suspicions or claims that Medicaid is creating a disincentive to work. This claim can be rejected by evidence produced by the Oregon Health Insurance Experiment which measured several outcomes, including impact of Medicaid on the labor market, by comparing individuals who were included in Medicaid expansion versus those who were not and found that being on Medicaid did not lead to any changes in employment status (Baiker et al., 2013) therefore concluding that Medicaid does not create a disincentive to work.

Additionally, evidence from work requirements implemented in the TANF program have shown that incorporating work requirements is not successful in increasing employment or earnings and does not result in individuals getting out of poverty (Center on Budget and Policy Analysis, 2018). Studies from TANF programs in Kansas where strict work requirements were implemented in 2011 used follow up data on people who lost TANF benefits due to work sanctions and concluded that, four years later, more than one-third of the people who lost TANF had no earnings, almost 70% had no earnings or earnings below "deep poverty level", and more than 80% had no earnings or earnings below the federal poverty level (Center on Budget and Policy Analysis, 2018). Additionally, research showed that TANF recipients who had significant barriers to employment still did not exhibit significant increases in finding work compared to

participants who were in the same work programs and not under a work requirement stipulation (See Appendix G) (Center on Budget and Policy Priorities, 2016). According to the Health and Human Services Finance Committee's fiscal note on the bill, approximately 398,000 Minnesota MA recipients will be subject to the work requirements and have estimated based off data from Minnesota's TANF program, known as MFIP, that about 20% of this group will lose MA coverage (Minnesota Committee on Budget and Finance, 2018). This estimate predicts approximately 79,600 Minnesotan's left without health insurance thus likely making it more difficult for them to seek care and medications to keep them healthy enough to participate in the workforce.

Critics of the new bill explain that most Minnesotans without a disability who are on Medicaid are already working (This is Medicaid, 2018) citing statistics that illustrate that more than 65% of these individuals are currently working, and 73% are living in families where at least one person is working (KFF, 2018). Additionally, the bill neglects to consider the various factors that have been illustrated through research that are contributing to the remaining individuals difficulty finding work, such as lack of access to education, jobs with predictable hours, affordable child care and transportation (This is Medicaid, 2018). Studies have shown that 35% of adults with dependents have a health condition that limits ability to work but does not qualify them for social security disability benefits (This is Medicaid, 2018). Additionally, this policy change could backfire causing those who are working to lose coverage, by forcing individuals who are already employed to prove it by jumping through administrative hoops and filling burdensome paperwork while navigating a complicated system which could lead to them losing coverage, not because they are not participating in the work requirement, but because they

may not be able to navigate the complicated systems of paperwork that also has chance of administrative error (Journal of American Medical Association, 2018).

Many health advocates argue another potential unintended consequence will be that individuals who are temporarily disabled might be pressured into seeking more long-term disability status by filing for disability with SSA, which might keep them out of the workforce longer term than they had originally planned just to keep their health insurance (NAMI Minnesota, 2018). Additionally, many severely mentally ill individuals fall through the cracks of these systems, unable to navigate the complexity of programs and also not deemed disabled by Social Security (NAMI Minnesota, 2018) this is likely as a result of barriers from their illness. Therefore, this requirement would significantly negatively impact this population who, on paper, may not be exempt from the requirements and appear to fit into category of "qualified individuals" when they face significant barriers. This illustrates that the specific requirements are not a logical fit to the perceived problem or the target population, and create risk of several unintended consequences that could make the perceived problem of unemployment even worse.

- **How will Medicaid Work Requirements impact costs?**

If the Medicaid work requirement is meant to address problems of cost, this may also be counterproductive as there is a potential for Medicaid work requirements to result in unintended consequence of increased cost. For example, Minnesota advocacy organization "This is Medicaid" points out that if people lose coverage due to inability to comply with work requirements, they will rack up increased costs through emergency room visits resulting in higher rates of uncompensated care (This is Medicaid, 2018). Without access to regular preventative care, there is a potential for increased cost through treatment of more serious illnesses down the road that were not caught or treated early due to inability to access care (This

is Medicaid, 2018) and data from the Minnesota Department of Human Services illustrates that with each chronic condition health care spending increases significantly (See appendix I) (Minnesota Department of Human Services, 2018). Additionally, on an individual level, loss of coverage will result in significant financial hardship, as data from The Oregon Health Experiment shows that Medicaid decreases overall financial hardship and decreases chances of individuals having unpaid medical bills sent to collections (Baiker et al., 2013).

As outlined by CMS in the 2018 letter to states, the demonstration does not allow states to use Medicaid funding to finance any services related to the work requirements. The bill outlines several areas that would need additional funding, including administrative costs of monitoring and tracking eligibility. The bill also calls for the use of several services including "career planning, job training, referral, or job support services" (MN House of Representatives, HF 3722), however does not provide any guidance on how these services will be developed or financed. A concrete plan for administration and financing of the bill is unclear and inadequate at this point. The bill also calls for monthly reporting requirements to track whether individuals comply. As outlined above, this will likely require several case workers to monitor these requirements on both a state and local (county) level to help clients navigate this process, and file paperwork which could lead to increased costs on the burden of state and county authorities (potentially funded through increased taxes) and cuts to other services (This is Medicaid, 2018). Lessons learned from work requirements added to the TANF program have shown that monitoring TANF recipients compliance to work requirements is "burdensome and costly for states" and results in states spending "significant staff time to tracking hours rather than providing direct service to individuals that could improve their prospects for securing employment or make them more job-ready." (Center on Budget and Policy Analysis, 2013).

The concerns of increased costs to support administration and financing of this policy are supported by the fiscal analysis by state and county authorities that have already predicted that implementing the Medicaid work requirements could result in significant increased administrative costs. Fiscal notes have projected that the state will need to hire an additional 65.5 FTE positions to implement these work requirements (Minnesota Department of Management and Budget). Additionally, the fiscal note produced by the Department of Management and Budget describes that there will be additional impact in loss of federal funding, explaining that the federal match for adults is 90% whereas the federal matching for coverage of those with disabilities is at a lower rate of 50% (Minnesota Department of Management and Budget, 2018). Therefore, if several of the expansion adults lose coverage and more individuals instead seek disability status, the state is losing funds through lower matching rates from the federal government. Additionally, they estimate that the policy change will result in an increase in State Medical Review Team (SMRT) applications, which is a way for individuals to be determined disabled by the state if have not yet achieved disability status through the Social Security Administration but anticipate disability lasting more than twelve months. This will put further pressure on these departments with increases in workload and will require additional hires in these departments as well (Minnesota Department of Management and Budget, 2018). Opponents of the bill argue, based from the fiscal note produced, that the implementation could cost the state almost 7 million dollars and result in a loss of 110 million dollars in federal funds (Star Tribune, 2018). The Association of Minnesota Counties has testified against the bill, citing that several counties expect significant costs as a result of hiring of staff to monitor these requirements which would counteract any potential savings. For example, Hennepin County is estimated to need around 250 new caseworkers with estimated cost of approximately 17 million

to implement this (NAMI, 2018). St Louis County has an estimated need to hire an additional 30 workers with an increase cost of 2 million (NAMI, 2018). State agencies have concluded, from the fiscal note by the Health and Human Services Finance Committee, that although the original intent of the policy is cost savings, that costs savings are "improbable" due to the administration and financing costs of implementation (Minnesota Council on Disability, 2018).

Additionally, the majority of spending in Minnesota on Medicaid coverage is for the elderly and disabled populations (see Appendix H). According to the Minnesota Department of Human Services Medicaid recipients in Minnesota with a disability or blindness make up eleven percent of the total Medicaid population in Minnesota however they accounted for thirty-eight percent of Minnesota's Medicaid health care spending (Department of Humans Services, 2018). Additionally, recipients over the age of 65 account for six percent of Minnesota's total Medicaid population. However, they make up twenty-two percent of spending (Department of Humans Services, 2018). Mandating work requirements on populations who are not those who make up the bulk of costs appears to be counterintuitive to solving the problem. Given the breakdown of costs, it would be more beneficial to target the populations that are costing the most (elderly and disabled) perhaps by providing more wrap around services for less intensive levels of care which will result in a decreased amount of medical costs and lower spending rates in these higher utilization populations. This is something that the state has been striving to do through Home and community based services in hopes of saving costs in the long run (Minnesota Department of Human Services, 2018).

This analysis of how Medicaid work requirements might impact costs illustrates that a solid plan for the administration and financing to support this policy is severely lacking. The

policy is not efficient or feasible at this time and would likely result in an increase in costs on state, county, and individual levels.

- **Unintended Consequences: Who will be affected the most and how does this impact access to care?**

How might Medicaid work requirements impact marginalized and vulnerable groups?

Past research on sanctioning in welfare programs such as TANF have shown that there is a risk of racial disparities in sanctioning, especially amongst long term program users, resulting in black welfare recipients being sanctioned more often than whites. This affect is especially true in counties where more conservative/republican ideology is more prevalent (Fording, Soss, and Schram, 2011). Additionally, historical research on sanctioning in welfare programs such as TANF have also been shown to impact those with lower incomes and less education (Fording, Soss, and Schram, 2011). Additionally, advocates argue that these work requirements will also largely negatively impact populations who are severely mentally ill, yet not deemed disabled under SSA (NAMI Minnesota, 2018).

How might Medicaid work requirements impact enrollment accomplishments of Medicaid Expansion?

Monthly enrollment in Medical Assistance in Minnesota on average, as of 2016, was about 1.1 million, and had increased by about 47% from 2012 to 2016 as a result of Medicaid expansion (Minnesota Department of Human Services, 2018). Medicaid expansion increased access to coverage for many Minnesotans and achieved the lowest statewide uninsured rate in history, resulting in Minnesota being one of 7 states with an uninsured rate of less than 7% (KFF, 2016). Policy analysts argue that expansion has resulted in net savings for several state budgets as a result of several factors including lower matching rates and increased revenues from taxes

on health plans and providers who see an increase in enrollment as a result of expansion (Center on Budget and Policy Priorities, 2016). Medicaid expansion has been argued to improve quality of care for more Minnesotans and actually saved the state more than $156 million in costs since 2013 (Office of Governor Mark Dayton, 2017). Additionally, it is estimated that Medicaid expansion allowed the state of Minnesota to increase federal funding by 2 billion dollars a year and led to coverage of more individuals at a lower cost (Office of Governor Mark Dayton, 2017). The Medicaid work requirements would likely negate this progress and reverse these accomplishments by putting 398,000 Minnesotan MA recipients (Minnesota Department of Management and Budget, 2018) at risk of losing coverage.

Evidence from work requirements implemented to the TANF program in Kansas in 2011 showed a sharp decline in caseloads, decreasing by over half in a four-year period. However, the majority who were cut off access to the program did not make significant gains in employment or earnings, and the majority remained poor or became even poorer now left without a safety net (Center for Budget and Policy Analysis, 2016). Medicaid enrollment could see similar effects with the incorporation of work requirements. However, instead of being cut off from access to cash assistance, they will be cut off from access to health care.

Summary of Policy Analysis

The solution of imposing work requirements does not adequately fit the perceived problems presented by Republican legislators in several areas, and the framing of the problem by these legislators is often misguided or inaccurate. Therefore, the response of imposing these work requirements is not an efficient policy solution as it could increase costs and be counterproductive resulting in additional problems through unintended consequences. The policy is not equitable as it will have the most significant negative impact on Medicaid recipients, who

by nature are individuals living in poverty, marginalized groups, and those with significant impairments and disabilities. Minorities are already more likely to be uninsured (KFF, 2016) and the Medicaid Work Requirement could exacerbate these inequalities even more. As outlined above, historical research on incorporating sanctions such as work requirements to other welfare programs such as TANF have shown that there are racial and class disparities amongst those who are sanctioned, showing that blacks, those with lowest incomes, and lower levels of education are negatively impacted to a higher degree than others (Fording, Soss, and Schram, 2011). The Medicaid Work Requirement has the potential to significantly deteriorate quality of life in several areas for some of Minnesota's most vulnerable populations. From a social work lens, this is in strong disagreement with core principles and ethics of social work and would likely lead to further disenfranchisement of marginalized and vulnerable populations.

Conclusion and Recommendations

There has been a longstanding debate throughout history around attaching work requirements and stipulations to welfare programs. In January of 2018 this debate resurfaced with the announcement that CMS is allowing states to apply for demonstrations through section 1115 waivers to implement work requirements to Medicaid, the nation's public health insurance program for low income individuals. There appears to be various framings of the problem with claims from conservative policy makers and health experts including: 1) there are too many unemployed individuals on Medicaid, 2) unemployment of Medicaid recipients will lead to poor mental and physical health, 3) Medicaid as is creates a disincentive to work, 4) individuals are abusing the Medicaid program, and 5) costs of Medicaid spending need to be decreased

Conservative lawmakers in Minnesota, as well as other states, and conservative health policy experts argue that Medicaid work requirement will address the above outlined problems.

They argue that tying work requirements to eligibility for health insurance will improve the health outcomes for Medicaid recipients (CMS, 2018) citing studies that link unemployment to poorer health outcomes. They also report that this will help "pull people out of poverty" and decrease dependence on Medicaid while reducing costs. However, opponents of the work requirements argue that this policy change is counterproductive, and attempts to address a "nonexistent problem" because the majority of people on Medicaid are working. Opponents also argue that there will be several unintended consequences.

Given the history of this debate, the analysis of the problem, and analysis of the policy change proposed through HF3722/SF 3611 bill introduced in Minnesota, the Medicaid work requirement should be strongly opposed for the following reasons:

- Medicaid work requirements create a barrier to necessary mental and physical health care which will lead to worse health outcomes in the long run;
- Medicaid work requirements address a "nonexistent" problem of unemployment, and could have unintended consequences of creating an additional barrier to employment;
- Medicaid work requirements could actually increase costs on state, county, and individual levels;
- Medicaid work requirements will reverse progress achieved by Medicaid expansion;
- Research on work requirements attached to other social insurance or welfare programs has been proven to be ineffective at increasing employment or earnings and result in further poverty;
- Medicaid work requirements are not efficient, feasible, or equitable and could disproportionately impact vulnerable and historically marginalized populations such as minorities, those with the lowest incomes, and those with lower education levels

There is strong evidence to support the stance that Medicaid work requirements should be strongly opposed. From a social work lens, the Medicaid work requirements creates a barrier to accessing physical and mental health care, specifically targeting some of the state's most vulnerable populations, and is in distinct opposition with core social work values of human rights, dignity and worth of the person, and social justice.

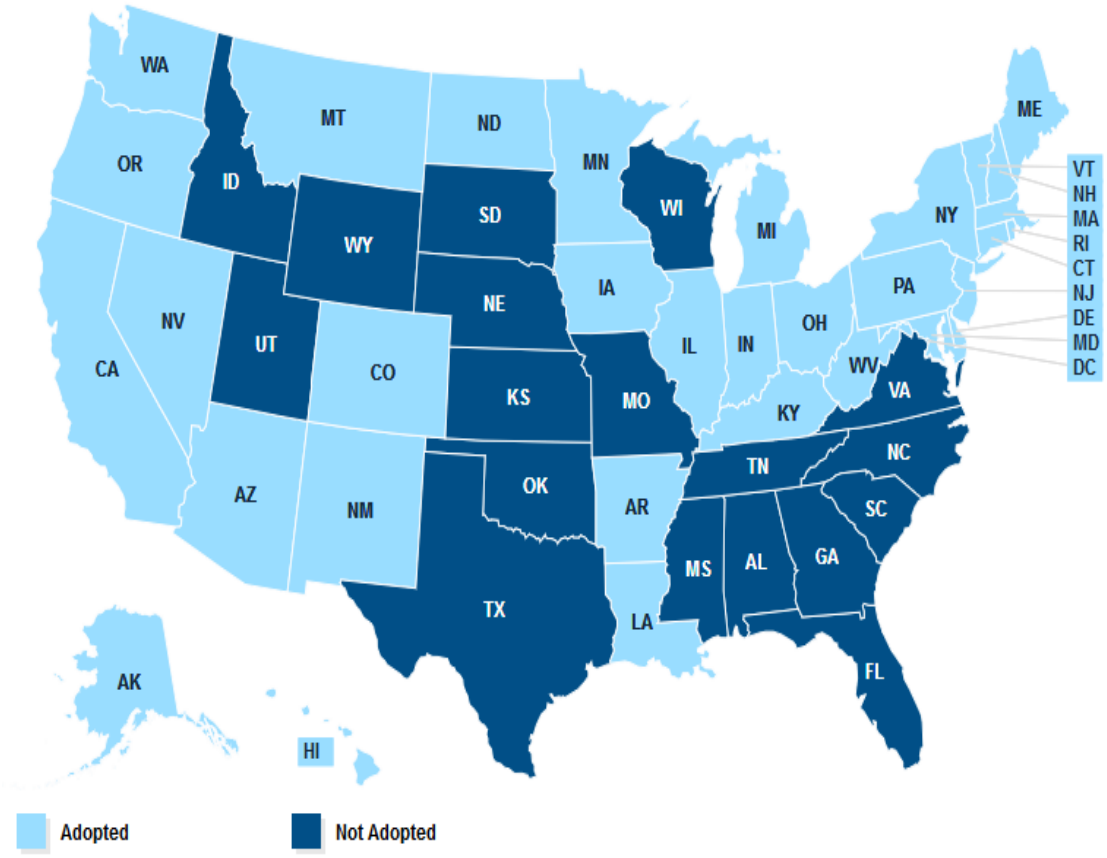
Recommendations

It is strongly recommended that lawmakers oppose the bill HF3722 which would attach work requirements to eligibility for Medical Assistance. Instead, lawmakers should advocate for continuing to decrease barriers to accessing necessary medical and mental health care by streamlining eligibility processes in order to allow for Medicaid recipients to get the necessary medical and mental health treatment that will make them healthy enough to rejoin or continue to participate in Minnesota's workforce. Additionally, lawmakers should advocate for increased funding or increased use of Medicaid reimbursable services for employment and furthering education supports and vocational rehabilitation programs. It is recommended that voluntary work programs be pursued over mandatory work requirements, as there is evidence that the former approach has more significant impact on meaningful employment and increases in earnings and that these gains are sustained over longer periods of time when comparted to mandatory work requirements (Center on Budget and Policy Priorities, 2016). Lawmakers, policy experts, and advocates should also pursue more targeted wrap around services for the elderly and disabled populations that are resulting in the most Medicaid spending in order to more effectively address issues of cost. Lastly, lawmakers should further examine the role that low wages, lack of transportation and lack of child care play into ability to achieve gainful employment and begin to craft policies to address these issues that are a more accurate cause of

the problem in order to truly improve the overall health and wellbeing of Minnesota's recipients of Medical Assistance.

Appendix A

Status of State Action on the Medicaid Expansion Decision

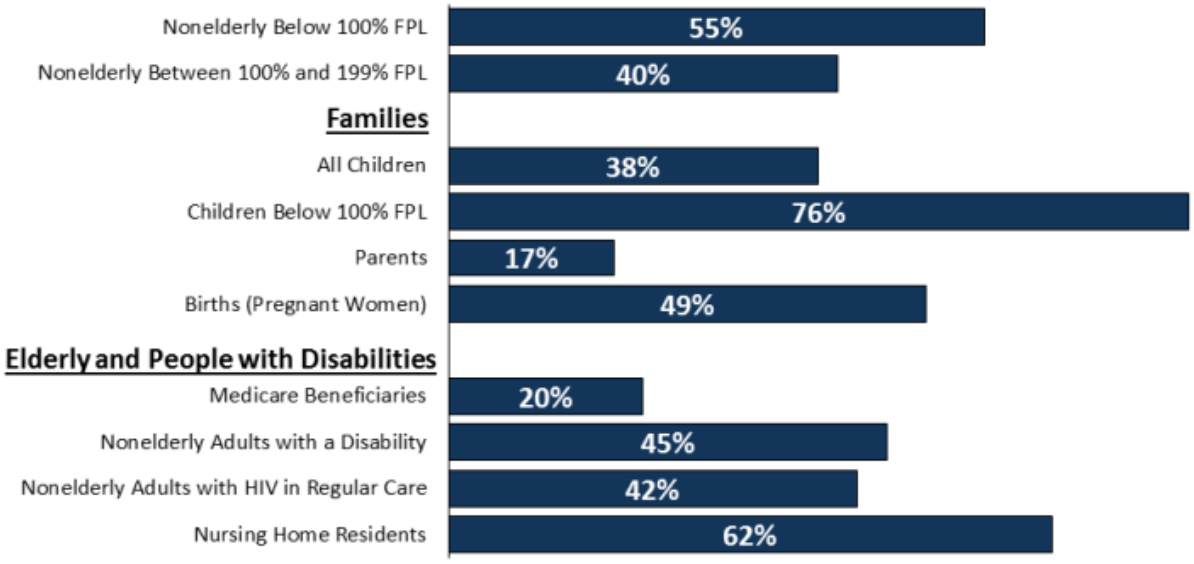


(Kaiser Family Foundation, 2018)

Appendix B

Figure 4

Medicaid plays a key role for selected populations.



NOTE: FPL-- Federal Poverty Level. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016.
SOURCES: KFF analysis of 2017 Current Population Survey, Annual Social and Economic Supplement; Birth data -Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, KFF, October 2016.; Medicare data - Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2018), 2013 data; Disability - KFF Analysis of 2016 ACS; Nonelderly with HIV - 2014 CDC MMP; Nursing Home Residents - 2015 OSCAR/CASPER data.

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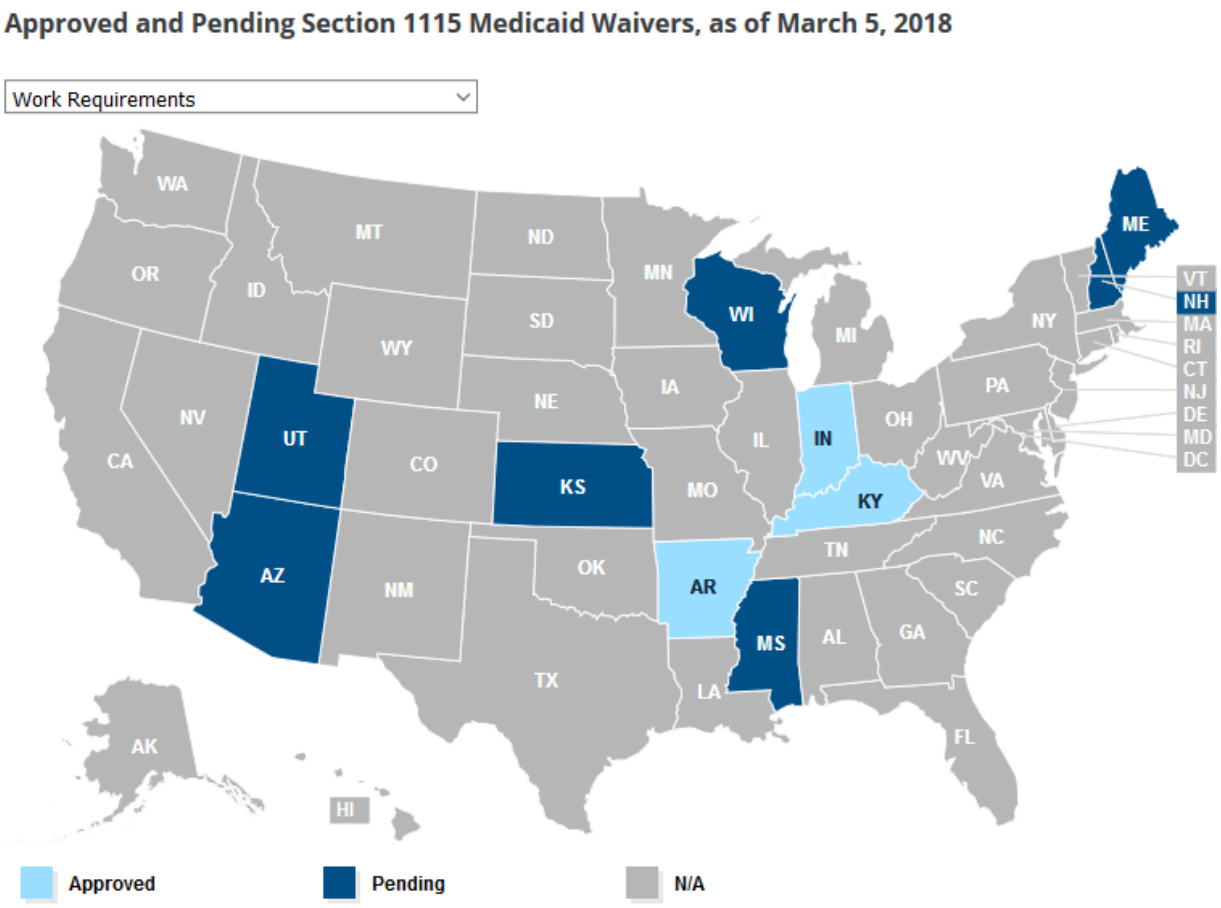
(Kaiser Family Foundation, 2018)

Appendix C



(Kaiser Family Foundation, 2018)

Appendix D

Table 1: Summary of States' Section 1115 Work Requirement Waivers Submitted to CMS as of January 12, 2018

	AR	AZ	IN	KS	KY – approved	ME	MS	NH	UT	WI
Covered Populations										
Expansion adults	X	X	X		X			X		
Traditional adults*			X	X (parents 0-38% FPL)	X	X (parents 0-105% FPL)	X (parents 0-27% FPL)		X (parents 60-100% FPL; childless adults 0-100% FPL)	X (childless adults 0-100% FPL)
Common Exemptions										
Age	50+	55+	60+	65+	65+	65+	65+	65+	60+	50+
Disability/ medically frail	X	X	X		X	X	X	X	X	X
Drug treatment	X		X		**	X	X	X	X	X
Students	X	X	X		X		X		X	X
Catastrophic event	X	X			**					
Caregiving	X	X	X	X	X**	X	X	X	X	X
Unemployment compensation	X					X			X	X
Common Work Activities										
Employment	X	X	X	X	X	X	X	X		X
Job Search	X	X	X	X	X	X		X	X	
Job Training	X		X	X	X		X	X	X	X
Volunteer/ community service	X	X	X	X	X	X	X			
Education	X	X	X	X	X	X		X		
Hours Required	80/month	20/week	Up to 20/week	20-30/week	80/month	20/week	20/week	20-30/week	3 consecutive months of job search/training unless working 30/week	80/month

NOTES: Specific details, such as the criteria to establish disability, type of educational programs permitted, whether caregiving extends beyond dependent children up to age 6, and qualifications for certain work activities, vary by state. States may provide additional exemptions or work activities. *Other groups, such as Transitional Medical Assistance, family planning only, or former foster care youth, may be included in some states. **In KY, drug treatment is a work activity, not an exemption. KY enrollees can seek good cause exemptions if they can verify one of the following in their month of noncompliance: disability, hospitalization, or serious illness of enrollee or immediate family member in the home; birth or death of family member living with enrollee; severe inclement weather including natural disaster; family emergency or other life-changing event such as divorce or domestic violence. In addition, 1 primary caregiver of a dependent minor child or adult with disabilities per household is exempt, and caregiving for a non-dependent relative or another person with a disabling medical condition is a work activity in KY.
SOURCE: Kaiser Family Foundation analysis of states' Section 1115 waiver applications posted on Medicaid.gov.

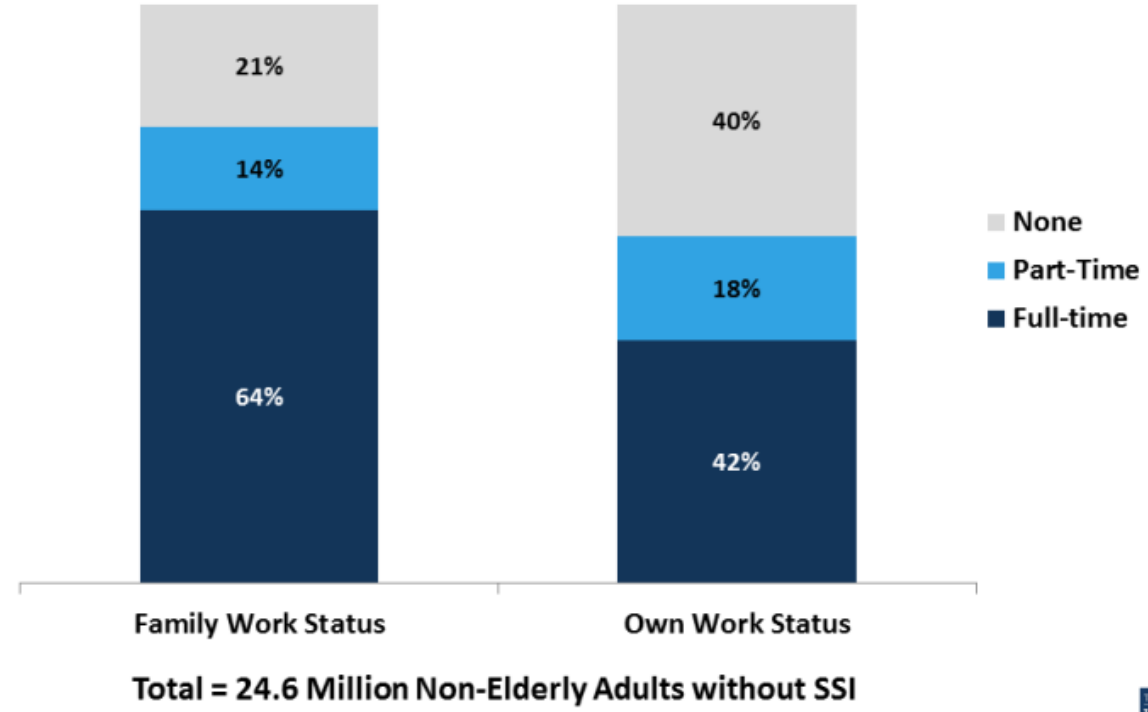
KFF | *Medicaid and Work Requirements: New Guidance, State Waiver...*

(Kaiser Family Foundation, 2018)

Appendix E

Figure 1

Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016



Total = 24.6 Million Non-Elderly Adults without SSI

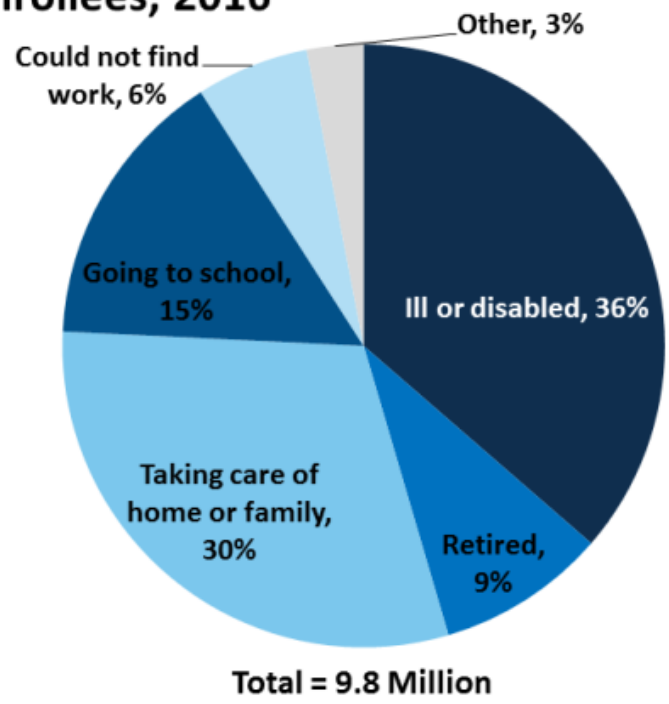
NOTE: Totals may not add due to rounding. Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

(Kaiser Family Foundation, 2016)

Appendix F

Figure 6

Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016



Total = 9.8 Million

NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

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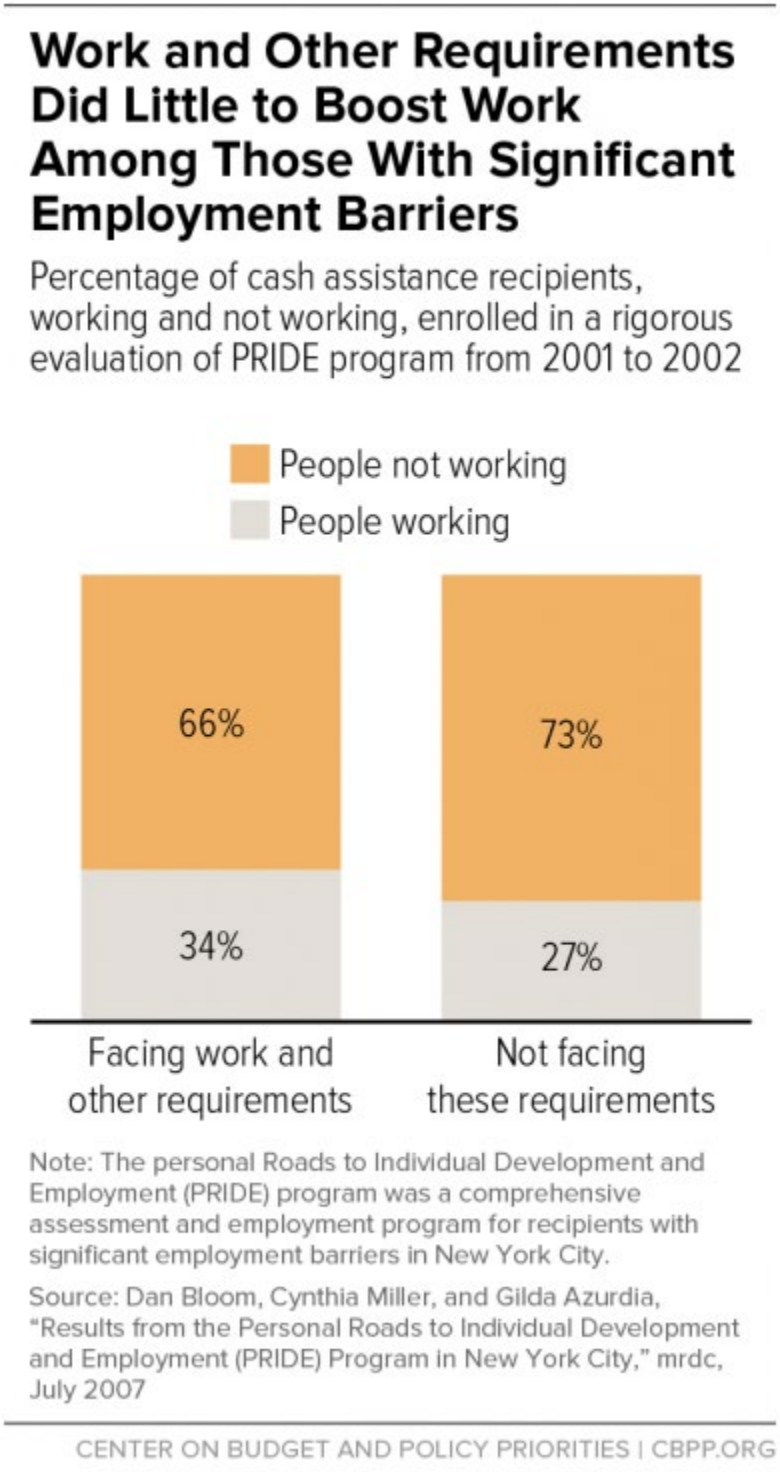
(Kaiser Family Foundation, 2018)

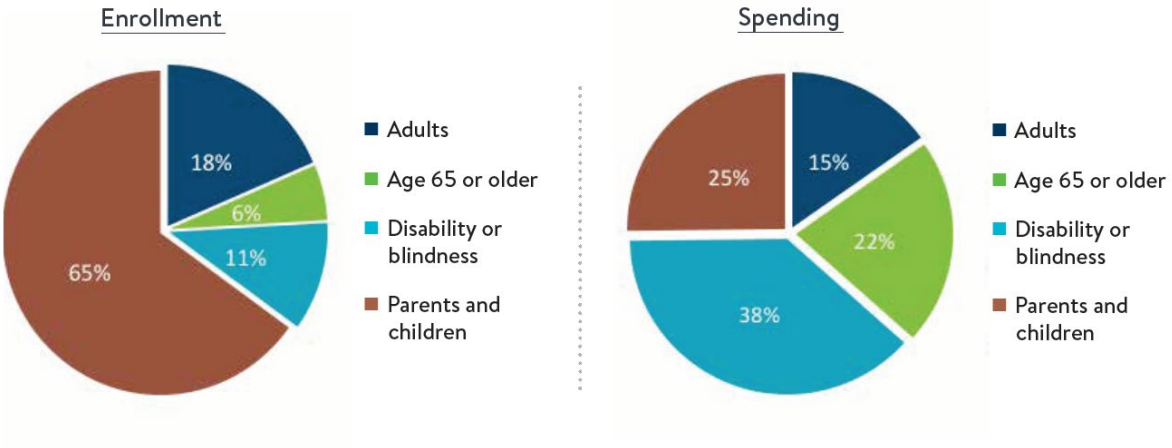
Appendix G



(Center on Budget and Policy Priorities, 2016)

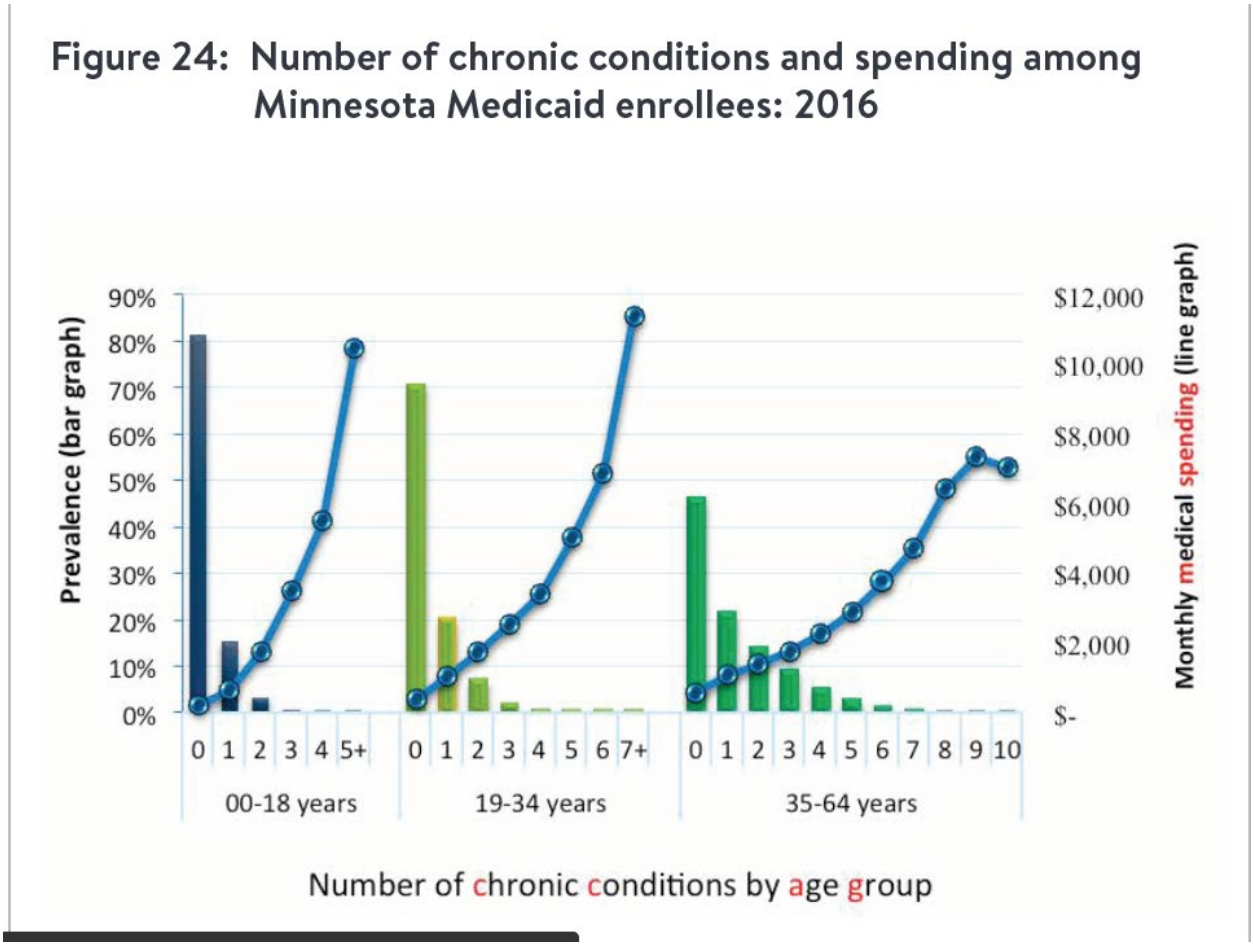
Appendix H

Figure 15: Minnesota Medicaid enrollment and spending by eligibility category



(Minnesota Department of Human Services, 2017)

Appendix I



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